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States/Feds Try Out New Roles for High-Risk Pools

In 1976, Minnesota and Connecticut created the first state high-risk health insurance pools. Today, 33 states have high-risk pools, which are mostly non-profit associations that offer state-supported insurance to people who can't find coverage in the individual market because of a preexisting condition. The plans sell to a tiny niche: people who are rejected because of their health, but who can afford premiums that are often half again as much as those of a normal policy.

Altogether, by the end of July 2003, these risk pools covered 172,845 individuals. With more than 43 million Americans uninsured, it would be easy to overlook this minute piece of the U.S. health-care system. But high-risk pools are a unique and crucial source of coverage – and their importance is growing.

First, retiree health coverage is vanishing. Only a third of current workers said they expected to receive it, yet 55 percent of adults 45-64 years old have at least one chronic condition that may make it difficult or impossible to find coverage on their own.

Second, the pools allow experimentation with individual coverage. Recent federal initiatives seek to test individually owned insurance by channeling more, and sometimes lower-risk, people into the pools. Some states are wary of these efforts. They're trying out innovative approaches that use the pools for their traditional purposes: the sharing and managing of very high-risk individuals. Decades of studies show that 5 percent of the population accounts for well over half the spending on health.

EXPANSION IS COSTLY

States have a variety of criteria for enrollment in a high-risk pool. One of the the fastest ways to become eligible is to try to buy insurance and be turned down for health reasons. Some states accept people who are only offered partial coverage, or who are offered higher-than-normal prices that are above the rates set by the pool. In 13 states, anyone with one of a list of conditions – including diabetes, cancer, hemophilia and asthma – is automatically eligible to enroll, because care for that condition will almost certainly be denied in the individual market. Wisconsin has a similar provision for HIV/AIDS alone.

Several federal initiatives have expanded the number of people who may qualify for coverage in a high-risk pool. The first was the 1996 Health Insurance Portability and Accountability Act (HIPAA), which allowed states to use their pools to meet a federal requirement to make insurance available for people who lose employer coverage after being covered for at least 18 months. All but a handful of the states with high-risk pools have qualified to use their pools for this group.

The second initiative was the 2002 Trade Adjustment Act (TAA), which provides funding to help states create high-risk pools or to modify existing pools to meet federal standards, as well as funding to help offset pool losses. The TAA also provides tax credits for people who lose their jobs because of trade-related activity. As of the end of February, 13 states had acted on a provision that lets them designate the pools as a place where displaced workers may use their TAA tax credit to buy coverage.

The pools are attractive to federal policymakers looking for private-market approaches to expanding coverage because the pools don't seem to require new spending for administration and marketing. Since the pools all charge more than the market rate for their plans, they don't compete with commercial insurers. Furthermore, as long as the people who come to the pools are as healthy

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FOCUS ON...

Electronic Health Records: A Pot of Gold at the End of a Long Road

The failure to implement information technology in the medical sector is a costly one, in human lives and dollars. In 1999, the Institute of Medicine estimated that up to 98,000 Americans die in hospitals each year from medical errors, at a cost of up to $29 billion dollars a year.

Fortunately, there are ways to decrease medical errors and their costs. One of the most promising involves electronic health records (EHRs), online databases that provide access to a patient's medical history.

EHRs can reduce adverse events by providing crucial information at the point of care; lessen duplication of tests by allowing practitioners to learn that a colleague recently ordered the same test; create efficiencies by preventing practitioners from having to "hunt" for paper-based clinical information; and enhance decision-making through the provision of on-line clinical practice guidelines and reminders of recommended tests.

While advocates say that EHRs can save billions of dollars by reducing administrative costs, medical errors and duplication of tests, setting EHRs up -- and getting physicians to use them -- is far from easy.

First, the systems are expensive. According to the large Boston-based health-care system Partners Healthcare, implementing a system-wide EHR could cost $25,000 per provider (including hardware and software, training and conversion of paper records).

In addition, many physicians are reluctant to switch from paper to electronics. If the system is to be used in a physician's office, the office will have to be shut down for a few days for installation and staff training. Many physicians worry about compliance with federal privacy laws, and they fear that their EHR may not be able to communicate with systems in other physicians' offices and hospitals. (The federal government is spearheading an effort to standardize the elements in an EHR so that different systems will be able to "talk" to each other.)

Then there are the legal obstacles. The 1972 federal anti-kickback law prohibits anyone from "knowingly and willfully" receiving or paying anything of value to influence the referral of federal health-care business. And the physician self-referral laws (often called the "Stark" laws after their author, U.S. Rep. Fortney "Pete" Stark) prohibit a physician from referring Medicare patients for health services if the physician (or a family member) has a financial relationship with the service provider.

Providers have been fearful that they'll violate these laws if they pool their resources to set up EHRs, said Janet Marchibroda, CEO of the public-private coalition eHealth Initiative. Even giving a physician a handheld device to enable him or her to communicate with the hospital's EHR could be seen as a violation of those laws, if that physician referred even one patient to the hospital.

The new Medicare prescription drug law provides a legal safe harbor for electronic prescribing. But the law is not explicit about other information technology. The safe harbor provision "needs to be extended" to broader EHR activities, Marchibroda said.

FEW TAKERS SO FAR

Given all those barriers, it's not surprising that few health systems -- and even fewer physician offices -- have adopted EHRs.

According to a 2000 survey by the Harvard School of Public Health, only about 14 percent of primary-care physicians use an EHR. Physicians might be willing to bear the costs of implementation if they stood to reap most of the benefits. However, as most of the savings will likely accrue to insurers and employers – through averted duplication of tests and reduced hospitalizations – physician offices are unlikely to adopt EHRs on a large scale until the financial and logistical burdens are eased.

"Even though this technology saves money, there is a misalignment between those who pay for it, and those who benefit from it," Marchibroda said. The health-care system needs to be reformed so that physicians who deliver higher-quality care by using new technology are rewarded, she said.

Despite the obstacles, enthusiasm for EHRs is growing. Marchibroda's organization and the federal government are offering $3.86 million in grants to communities for creation of EHRs. In 2003, they received 133 applications from 42 states and the District of Columbia.

The national landscape is beginning to be dotted with public-private coalitions that are determined to set up EHRs. One of the oldest such efforts is in Indiana. Created by the non-profit Regenstrief Institute, the Indianapolis Network for Patient Care aggregates clinical information from hospitals, laboratories, radiology centers and physician offices, according to the network's chief investigator Dr. J. Marc Overhage.

The network is essentially a collection of databases, with one for each physicians' group, one for laboratories, and one for hospitals. "There are a series of agreements that define who can look at what, and when [so patient privacy is protected]," Overhage said. For example, when a patient goes to the emergency department, a physician there can tap into the network to generate an abstract on recent clinical activity, such as where that person received care and results of recent lab tests.

Overhage estimates that roughly half of the 3,000 physicians in central Indiana are network members. "This is a system that helps coordinate [clinical care]," Overhage said. "It wouldn't be easy to have each physician using his or her own EHR; they might not [be able to communicate with each other]." A study by Overhage in the Jan. 2002 *Annals of Emergency Medicine* showed that the EHR enabled one hospital to reduce emergency department charges by $26 per encounter.

In the East, the Delaware Health Information Network is setting up a statewide EHR. The network will enable patient-authorized providers to electronically request information from data contributors.

In Rhode Island, state officials have joined with the CEOs of health-care institutions and other businesses to form the Rhode Island Quality Institute. Members are currently selecting a community in which to establish an EHR system that will link physician offices to hospitals and other facilities. Using grant money, the institute plans to provide software, hardware and technical support to physicians in the community at no charge. Each physician also will be paid $25,000 a year just to use the system.

"We made the decision that doctors cannot afford to do this on their own, so we're going to do it for them," said Laura Adams, president and CEO of the institute. She belives that by capturing errors, the system will soon more than pay for itself. "We believe that it's a sustainable business project that will give the ultimate benefit to the patient," she said. "Right now, people are operating in an information-free zone."

—Diana Mayes is an Intern with the Forum for State Health Policy Leadership

HIGHLIGHTS

CHILDREN'S HEALTH

Program Cuts

Florida legislators have approved a bill that will limit the number of children eligible for KidCare, the State Children's Health Insurance Program. Since its inception in the early 1990s, KidCare has been open to any parent whose child is uninsured. Under the new law, parents who have employer-provided health insurance will no longer be eligible unless the premium would cost more than 7.5 percent of their gross pay (parents must send the state pay stubs as proof). Lawmakers voted to spend $25 million in state and federal funds to enroll the 90,000 kids who joined the waiting list for the program from last summer to Jan. 30 — but new, more stringent eligibility requirements will mean that as many as 20,000 children will be dropped from the roles. (The 23,000 children who were added to the waiting list since Jan. 30 will not be included in the $25 million bailout.) The law also replaces year-round open enrollment with two enrollment periods, requires more proof of parental income and gives the Governor the authority to disenroll children in the program on a "last-in-first-out" basis. Supporters of the bill emphasize that the changes will help preserve the subsidized health insurance program, as well as immediately enroll kids who have been on the waiting list. However, opponents argue that the new restrictions will severely limit future access to the program. The bill now goes to Gov. Jeb Bush, who is expected to sign it.

Autism and MMR Vaccine

Five years after they linked the childhood measles-mumps-rubella vaccine to autism, 10 of the 13 researchers have retracted their conclusion. In a statement published in the March 6 issue of the British medical journal the *Lancet* (where the initial findings were published), the researchers said there were insufficient data to indicate that the vaccine causes autism. The original study has been blamed for the sharp drop in the number of British children being vaccinated, and for an increase in measles outbreaks. The study came under scrutiny last month after the *Lancet* editor disclosed a blatant conflict of interest: the lead researcher in the study also was working with a legal aid society that was investigating whether families with autistic children could sue on grounds they were immunized. In addition, research closely linked to the *Lancet* study was financed by an $89,000 grant from the legal aid service.

ADOLESCENT HEALTH

Taking the Pledge

A new study says that teens who make a public pledge to abstain from sex until marriage have fewer sexual partners and get married earlier. They also have the same rates of sexually transmitted diseases as their counterparts who make no such virginity pledge. In a study presented at the National STD Prevention Conference on March 9, researchers revealed that the STD rates for whites who pledged virginity was 2.8 percent, compared with 3.5 percent for those who did not take the pledge. For blacks who took the pledge, the STD rate was 18.1 percent, compared with 20.3 percent for non-pledges; for Hispanics, the rates were 6.7 percent and 8.6 percent, respectively. The study also found that 59 percent of males who did not pledge abstinence used a condom during sex, while only 40 percent of male pledgers used a condom. Ninety-nine percent of surveyed non-pledgers and 88 percent of pledgers reported having sex before marriage. Researchers speculate that it is difficult to simultaneously promote abstinence and prepare for safer sex.

HEALTH INSURANCE

Costs Prove Worthy

While Rhode Island residents pay significantly more for their health insurance than the rest of the nation, they also are more satisfied with both their health care and their health plans, says a Department of Health report released March 8. The report, *RI Commercial Health Plans' Performance Report – 2002,* which examines commercial health-plan performance, compared 2002 data with data from previous years. The study showed that Rhode Island health plans were more profitable and their premium revenues were 41 percent higher than their national counterparts. Both medical expenses and administrative overhead were less than their national counterparts'. Rhode Island plans also performed favorably on clinical quality measures, and they scored higher on patient satisfaction. The report showed that commercial plans in the state excel at getting children and adolescents immunized, but they perform poorly when it comes to diabetes prevention and control, access to prenatal care and follow-up care after psychiatric hospitalization. Minorities were as satisfied as white members with their health plans and physicians, although fewer minorities indicated satisfaction with specialists and overall health-care services. The report author notes that with the dominance of Blue Cross plans in the state – in 2002, Blue Cross had 71 percent of the market share, up from 50 percent in 1998 – information about quality and cost is imperative.

Employer Coverage

Employers overwhelmingly support job-based health coverage, but rising premium costs are forcing them to shift the burden to their employers, says a March 9 report by the Commonwealth Fund. According to the report, *Job Based Health Insurance in the Balance: Employer Views of Coverage in the Workplace,* 59 percent of employers say it is very important to provide health insurance to their employees or contribute to the cost. To cope with rising health care costs, one-third of employees said they increased employee copayments or coinsurance, and 31 percent increased employee shares of premiums in 2002. A quarter of employees raised dedictibles and almost one-fifth eliminated or reduced benefits such as hospital stays, phsyician visits or prescription drug coverage. Employers "want to do the right thing for their employees, but are struggling to manage the rising costs of providing coverage," said Commonwealth Fund president Karen Davis, in a press release. Of employers who offer coverage, 67 percent says it improves employee health and 61 percent say it improves employee morale. To view the report in full, log onto http://www.cmwf.org

Scams on the Rise

According to a Government Accounting Office report sent to Congress, insurance scams are on the rise. Double-digit premium increases and the concomitant demand for affordable health care are creating an environment ripe for fraudulent health insurance plans that entice customers with low premiums and vanish before paying claims. The GAO survey found that 144 unlicensed operators pedaled insurance from 2000 to 2002. The vendors sold insurance policies to at least 15,000 employers, many of them small companies, and left behind at least $252 million in unpaid medical claims, about $200 million of which had not been collected at the time of the survey. Strategies proposed by witnesses at a March 3 Senate Finance Committee hearing to reduce fraud included giving the U.S. Labor Department more authority to act against illegal plans, allowing small businesses to join together to buy health insurance without being subject to state regulation, and increasing the number of health insurance fraud prosecutions by the U.S. Justice Department.

PUBLIC HEALTH

Asthma Rates Up

The asthma rate among U.S. residents shot up in 2002 to 7.5 percent, from 7.2 percent the previous year, says a Feb. 26 report released by the Centers for Disease Control and Prevention. Minorities suffered the highest rates of asthma, with 11.6 percent of American Indians and Alaska Natives and 9.3 percent of African Americans having an asthma diagnosis; the rate of asthma among whites was 7.6 percent. African Americans, Hispanics, American Indians and Alaska Natives were more likely that whites and Asians to report asthma attacks and disturbed sleep because of the disease. The report also found that African Americans were more likely to seek emergency room care for asthma-related problems and treatment, compared with only 14.5 percent of whites. Researchers noted that the rise in asthma rates could be the result of better diagnoses by physicians, a change in how patients are defining their illness or a true prevalence increase.

America is Moving

On March 9, America On the Move (AOM), a national, grassroots initiative that promotes healthy eating and active living, announced that twelve state affiliates will bring the AOM initiative to their communities. The affiliates include Colorado, Idaho, Indiana, Kansas, Michigan, Nebraska, Tennessee, Texas, Virginia, West Virginia and the communities of Santa Barbara County, California, and Saratoga County, New York. America on the Move, which was launched in July 2003, encourages Americans to make two small changes that add up to big differences: walk an extra 2,000 steps a day and eat 100 fewer calories a day. AOM affiliates will work with communities to engage individuals in making the small behavior changes. AOM offers an interactive website featuring a step tracker to log daily steps and monitor progress, healthy meal options and tips for eating 100 fewer calories each day. AOM also announced its partnership with *Prevention Magazine* and the American Podiatric Medical Association (APMA) to get Americans moving in the country's first National Walk to Work Day on April 2nd. For more, log onto www.americaonthemove.org or see *SHN* #404, 9/22/03.

SUBSTANCE ABUSE

Inhalant Program

On March 9, the Alliance for Consumer Education and the American School Counselor Association launched the Inhalant Abuse Prevention Program, an initiative aimed at educating parents about the dangers of inhalant use and tips for keeping their children and teens safe. Commonly called "huffing" or "sniffing," inhalant use can cause damage to the heart, lungs, kidneys and liver, and sometimes result in death. Inhalant products are easily obtained at grocery and hardware stores, and include nail polish remover, hair spray, canned whipped cream, felt-tip markers, spray paint, glue and cooking spray. ACE estimates that more than 2.1 million kids, aged 12 to 17, have used an inhalant to get high, and roughly 20 percent of students in America have intentionally abused a common household product to get high by the time they reach the eighth grade. Because inhalants are easily accessible they tend to be a drug of first use. Pennsylvania was chosen as one of the first states to implement the experimental program, in large part because the state's "driving under the influence" regulations specify that inhalants – solvents or any noxious substance – can be considered in a DUI offense. Five other states – Ohio, Virginia, Texas, Alabama and Alaska – also will participate in the program. For more about the program visit http://www.inhalant.org

PHARMACEUTICALS

Evaluating Canadian Pharmacies

On March 3, Minnesota announced its plans to develop a formal checklist to evaluate Canadian online pharmacies that apply to appear on the state prescription website. Last month, Minnesota launched *Rx Connect Online*, a website that lists prices for 829 brand-name and generic medications, as well as phone and email contact information for two Canadian pharmacies willing to sell prescription drugs to Americans. While state officials examined the Canadian pharmacies participating in the website, no formal evaluation system was used. Commissioner of the Department of Human Services, Kevin Goodno, noted that the department would begin using formal, detailed inspection forms in the evaluation of Canadian pharmacies, similar to the forms used by the state boards of pharmacy, in their inspection of pharmacies. On March 5, Goodno announced that the department also plans to conduct unannounced inspections of Canadian pharmacies. See *SHN* #412, 1/26/04, for more on Rx reimportation.

Reversal by Thompson

Tommy Thompson, secretary of the U.S. Department of Health and Human Services, appears to have changed his mind. On March 4, he told members of a House subcommittee that he "could support allowing drugs to be reimported from Canada if Congress put strict conditions on the practice," according to an article in *CongressDaily*. Thompson said he would support legislation to allow reimportation, if such a law would apply only to medications purchased from Canada and if it would provide HHS with the "resources to inspect the manufacturing and inspect the packages." In other news, U.S. Surgeon General Richard Carmona, MD, has been appointed to head a committee to investigate the reimportation of drugs from Canada. The other 12 committee members are all members of the Bush administration, but Thompson promised that the committee would make "a fair and balanced" examination of the practice. The committee will hold hearings with a range of interest groups to obtain their views.

WORTH NOTING

Conference Slate

✦ *Nursing Leadership: Rising on the Wings of Change*, April 17-21, Phoenix, Arizona, is the 37th annual meeting of the American Organization of Nurse Executives. Meeting topics include information technology and care delivery, workforce issues and evidence based research to transform care delivery. For more, visit http://www.hospitalconnect.com/aone/edandcareer/annualmeeting.html

✦ *Obesity Management: Prevention, Treatment and Coverage Strategies for Health Plans and Employers*, May 19-20, Houston, Texas. The premiere conference hosted by the Institute for International Research will provide a forum for stakeholders, including health plans, self-insured employers and healthcare providers to obtain the tools required to control costs and improve outcomes for the clinically obese. For more, visit http://www.iirusa.com/obesity/index.cfm

NCSL's SPRING FORUM

NCSL's Spring Forum, April 29-May1, Washington, D.C., will cover jobs and the economy, unfunded mandates and implementing the No Child Left Behind Act. Guest speakers include Mara Liasson, national political correspondent for NPR, and the Honorable Jonathan S. Adelstein, commissioner, Federal Communications Commission. Interested participants can register online at http://www.ncsl.org/forum/, or by calling Barbara Houlik at (303) 364-7700.

SAVE THE DATE!

The New Legislative Reality, July 19-23, Salt Lake City, Utah. Meeting topics include State budget shortfalls, the federal deficit, tax burdens, the nation's economy, Medicaid and outsourcing of jobs overseas. It's not too early to register! Housing and registration information is available online at http://www.ncsl.org/annualmeeting/Registration.htm

In Print

✦ *Addressing Coverage Gaps for Low-Income Parents*, published in *Health Affairs*, concludes that unless states expand Medicaid and the State Children's Health Insurance Program (SCHIP) to offer coverage to low-income parents, it is unlikely that parents living in poverty will gain health insurance coverage. The authors estimate that extending coverage to parents with incomes below 200 percent of poverty would likely cost in excess of $10 billion per year, but that extension would lead to coverage for 7.4 million, or 70 percent, of the 10.6 million parents who are uninsured. They further contend that Medicaid expansions would be far more effective than premium-assistance programs and tax credits at closing the coverage gap for poor parents. For the full study, log onto http://content.healthaffairs.org/cgi/content/abstract/23/2/225

✦ *Care of Children and Adolescents in U.S. Hospitals* is a new fact book from the Agency for Healthcare Research and Quality (AHRQ). The data on children's hospitalizations is drawn from the newest version of the "Kids' Inpatient Database." It provides an overview of hospital care for children, including the types of conditions for which children are hospitalized, the types of procedures they receive, the resource use associated with children's hospital stays, who is billed for the stays, and how children are discharged from the hospital. The fact book is available at www.ahrq.gov; you can request a print copy by sending an e-mail to ahrqpubs@ahrq.gov

✦ *Medicare's Future: Current Picture, Trends, and Medicare Prescription Drug, Improvement & Modernization Act of 2003* is an array of PowerPoint slides compiled by the Commonwealth Fund to help educate the public about the new Medicare prescription drug law. Slides include research and analytical findings on Medicare, as well as an overview of the drug benefit passed by Congress. The slides are available at http://www.cmwf.org/programs/medfutur/medicarechtpk_debate_659.ppt

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or healthier than the ones already in the pools, they won't harm the states, the thinking goes.

States have some concerns about this approach. First, there are start-up costs associated with administering new programs, products and eligibility groups. And, if the state has more restrictions (such as higher premiums or more stringent eligibility rules) on its high-risk group than the federal programs allow, the state must choose between liberalizing the rules for all participants (which would raise costs), or creating and maintaining two pools side by side.

States say it's a fallacy that adding people to the pool is free. High-risk pool premiums are typically 50 percent higher than those of comparable plans for people with normal health risks; still, those premiums don't cover all the costs. For the 29 pools in operation in 2002-2003, premiums covered only 57 percent of the costs. States made up the other 43 percent.

Some states have been hesitant to open their pools to large numbers of new members, even though in theory, doing so would help to spread the cost of the very sick people already enrolled. The reason? Although the new enrollees may not be as sick as the people who joined the pool as a last resort, the new members are still likely to cost more than they pay in. The healthier members of the new eligibility groups are likely to shun the expensive – and often limited – policies offered by the pools in favor of commercial coverage if it is available.

FEDS PROVIDE SOME $

Nevertheless, risk-pool guru Bruce Abbe, vice president of public affairs for the risk pool advocacy group, Communicating for Agriculture and the Self-Employed, sees nothing wrong with adding new people to the pools, as long as the feds recognize that these new groups likely will require additional funding.

It might not cover all the additional costs, but Congress stepped up to the plate with the TAA, appropriating $100 million for high-risk pools. Late in 2003, 16 states received TAA operating grants totaling just under $30 million to cover some of their losses. The operating grants are distributed based on the number of uninsured in the states. To qualify, pools must charge no more than 150 percent of standard premiums, and

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anyone eligible under HIPAA must be permitted to enter.

As of the end of February, with one month to go before the funds expired, three states with new high-risk pools – Maryland, South Dakota and New Hampshire – had received $1 million each from the $20 million that was available as seed grants.

Some states are holding back on qualifying for the TAA money because they are not sure that they can afford to guarantee open enrollment or lower premiums, as the feds require. Other states want to attract more people, not limit the size of the pool. Connecticut, New Mexico and Colorado (and likely Maryland soon) now subsidize pool premiums for low- income people, something Wisconsin has done since 1985. Three other states (Tennessee, Oregon and Washington) coordinate their pools with programs that cover low-income persons.

"Really catastrophic cases explode the pools," Abbe said. Historically, the sickest of the sick have gone into fully subsidized public programs, with comprehensive benefits, while risk pools offer more stripped-down care. High-risk pools are "the place for people in the individual market to go, not a place for groups to dump their unacceptable risks," he said. And that means neither groups nor public programs should be buying into the plans for individuals, he added (although he supports subsidies or credits that allow individuals to choose to join a pool).

FOR THE SICK ONLY

Nonetheless, several innovative states are embracing the idea that these pools are places to pay for expensive and high-risk care. How the pools are funded seems to be tied inextricably to who is allowed into the pools. (See *SHN* #388, 1/27/03)

Most pools are funded through assessments on insurers, and are managed according to techniques designed to reduce and spread risk. Maryland's recently formed high-risk pool is funded by a provider assessment, and this seems to have affected its approach to who should participate. According to Richard Popper, executive director of the state's high-risk pool, Maryland views its pool as an alternative to uncompensated hospital care. The board of the pool -- the Maryland Health Insurance Plan -- has instructed Popper to reach out aggressively to high-risk populations. He is inviting disease advocacy groups to help identify and enroll eligible members in the program, and the state Ryan White program, which subsidizes insurance for people with HIV/AIDS, will be participating in the pool. Popper added that the plan charges some of the lowest premiums in the country because Maryland's system of regulating hospital and insurance prices keeps those prices down for everyone.

In Indiana, the high costs that piled up after the Indiana Comprehensive Health Insurance Association (ICHIA) began accepting Ryan White enrollees almost did the program in. Indiana's program does not have a broad funding base, and it does not set a lifetime limit on costs (unlike most other pools, which adopt the $1 million lifetime maximum that is typical in private policies).

A few very high-cost cases seem to be driving Indiana's experience. Recently 40 patients with hemophilia incurred over $18 million in costs in a single year. The impact of a small number of very high-cost cases has led Doug Stratton, executive director of the Indiana pool, to ponder the connection between public and private funding of very sick people. It's not common for risk pools and Medicaid to join forces, he said.

Stratton believes that when people are catastrophically ill, they shouldn't depend on the private sector. He and the state Medicaid director are discussing whether to propose a Section 1115 Medicaid demonstration waiver to intensively manage care for a limited number of very ill people. "It doesn't matter what we call the program," he said. "We want to figure out how to get them the care they need."

Stratton found a way to mix public and private programs when he investigated the cause of the high costs in Indiana. The major cost is the purchase of clotting factor. Stratton discovered that certain entities, including community health centers and licensed hemophilia treatment centers, can purchase pharmaceuticals, including clotting factor, at federally defined low rates under Section 340B. He is seeking to contract with these centers to provide these services and bring costs down for this small but hugely important cohort.

California has taken the opposite route: move people back into the larger individual insurance market. Constrained by a $40 million budget (funded by cigarette taxes), California recently adopted an"incubator" approach for its Major Risk Medical Insurance Program (MRMIP) as a four-year pilot.

With more than 16,000 participants, a growing waiting list, a fixed budget and rising costs, California has capped benefits per enrollee at $75,000/year (with a lifetime maximum of $750,000) and the state now automatically "graduates" its participants after 36 months. Carriers in the individual market are required to offer at least one plan based on one that is available in MRMIP. "Postgraduates" are entitled to purchase these products on a guaranteed issue basis at 10 percent over the premium inside the pool. Since implementing the pilot, enrollment has dropped to 7,800 and there is not waiting list. The program could insure more 11,187 more high-risk individuals.

The challenge of keeping premiums affordable, even at 150 percent over the market rate, has led many high-risk pool plans to offer skimpy benefits with high deductibles. But the latest federal program may make the programs more complete. A section of the recent Medicare drug law creates health savings accounts – HSAs – tax-sheltered savings accounts to be used with high-deductible policies. HSAs seem tailormade to be used with pools, most of which sell policies with deductibles of $1,000 and up. States are developing new policies to coordinate with HSAs, because most of the states pools' current high-deductible plans have disqualifying lower deductibles for pharmaceuticals. *KL*

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GRAPHICALLY *SPEAKING*

States Enjoy a Reprieve from Surging Medicaid Costs -- But Brace for More

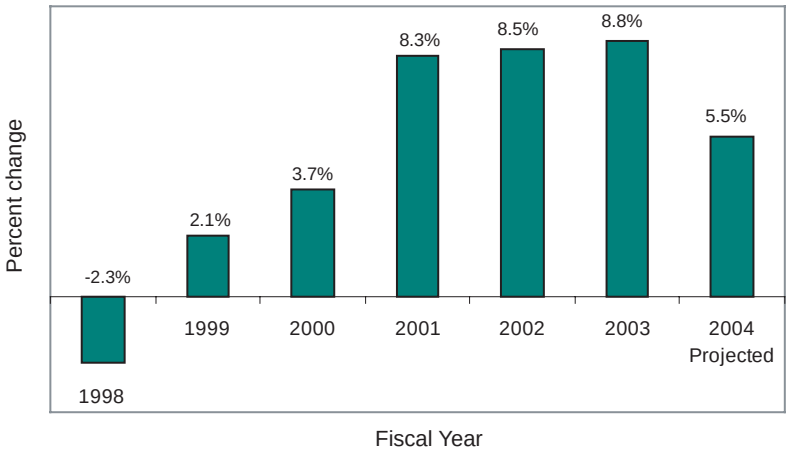
Since 2001, states have endured what has been called their worst fiscal crisis in 50 years. As revenues have fallen, Medicaid costs have increased, and states have tried to contain Medicaid costs as a way to help balance their budgets. In 2004, those efforts are expected to pay off, the Kaiser Commission on Medicaid and the Uninsured reported in "States Respond to Fiscal Pressure: A 50-State Update of State Medicaid Spending Growth and Cost-Containment Actions." The rate of growth in Medicaid spending is expected to slow to 8.2 percent, and the increase in enrollment is projected to slow to 5.5 percent.

Still, almost every state will implement further cost-containment in FY 2004, the Commission said. In total, 49 states and the District of Columbia reported that they planned to curtail Medicaid costs this year, by reducing provider payments, restricting eligibility and benefits, and increasing co-pays.

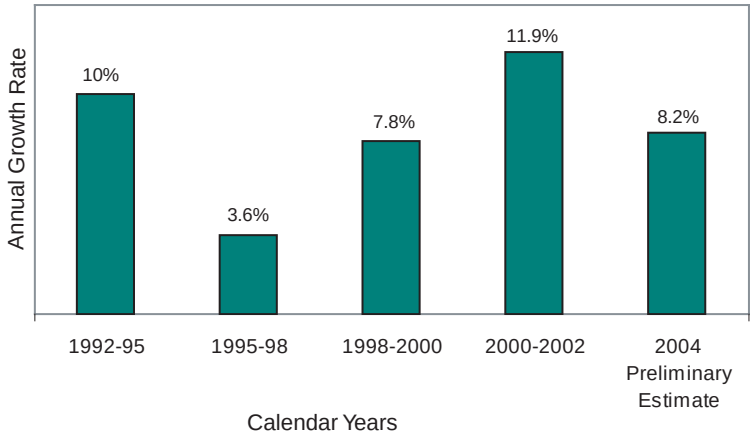
Last summer, Congress gave states a $20 billion windfall to help them pay for Medicaid. This slowed state Medicaid spending in FY 2004 to only 3.3 percent. Twenty-seven states reported that they used the fiscal relief to avoid, minimize or postpone Medicaid cuts or freezes. And the largesse helped many states fill shortfalls in their general fund budgets.

But states expect a significant adverse impact when the temporary fiscal relief expires in June. "Few states will have the fiscal resources available to fill the gap that it creates," the Commission said. When the fiscal relief ends, the percentage increases in the state cost of Medicaid in FY 2005 likely will be the highest experienced in many years. Proportionately, the impact of the expiration will be greatest in states with the lowest per capita incomes and the highest federal matching rates. *CK*

Percent Change in U.S. Medicaid Enrollment, FY 1998 - 2004



Average Annual Growth Rates of Total Medicaid Spending



Source: The Kaiser Commission on Medicaid and the Uninsured, *States Respond to Fiscal Pressure - A 50 State Update*, Januray 2004

FOR YOUR *INFORMATION*

Small Iowa Project Could Save Big Bucks

If all goes according to plan, a small pilot project in Iowa will serve as a model for long-term care – saving significant amounts of money, and improving the health of the frail elderly.

Dr. Robert Bender, a board-certified geriatrician with Iowa Health Systems, received a $500,000 grant from the U.S. Centers for Disease Control and Prevention to test whether using physician extenders to provide intensive preventive and wellness care to seniors will not only improve their health, but save money by reducing hospital admissions and emergency room visits by 30 percent.

Under the project (which was launched in January and is expected to last two years), physician's assistant Dave Michael monitors the health of and provides preventive care to 50 frail elderly patients at the Adel Acres Nursing Home, in Adel, Iowa. Working full-time, on-site, Michael performs such tasks as writing prescriptions, treating minor injuries that could otherwise become serious problems, and attending to chronic conditions such as diabetes and congestive heart failure (CHF). Bender oversees Michael's practice and the two do rounds together regularly.

"I've been a geriatrician for 20 years, and it has become clear to me that there has been a steady evolution of wellness and prevention programs for seniors," Bender said. "We also know a lot about the diseases and conditions that frail seniors are at risk for. The idea is to take everything we've learned about prevention and wellness and apply it directly to seniors."

Bender and Michael deliver primary prevention, such as providing flu and pnuemoccocal vaccinations; secondary prevention, for example, identifying hypertension and treating it "maximally"; and tertiary prevention, or treating congestive heart failure and other illnesses that already involve an organ. They also encourage the nursing home to provide services that are proven to be associated with healthy aging, such as socialization, fresh air and regular exercise. Michael plans to give some residents ankle weights, to help them strengthen their leg muscles and thereby reduce falls.

"My job is to prevent hospital visits and unnecessary suffering by diagnosing illnesses early, before they become serious health problems," said Michael. "I feel like we've already been able to do that in the short time we've been here."

Other health-care settings are setting up similar systems, using nurse practitioners and other physician extenders to bring evidence-based medicine to the bedside, Bender said. The difference is that "we're looking at it scientifically." An economist is helping Bender and Michael examine five years' worth of health-related events at the nursing home (such as calls for ambulances and hospitalizations), so that they'll have a basis with which to compare this year's experience.

Bender couldn't say whether there will be a sufficient supply of physician extenders in the coming decades to fulfill the needs of the elderly in nursing homes and other care settings. Nursing homes have historically had a difficult time hiring and retaining nurses and other health-care professionals. A survey by the American Health Care Association found that, in 2002, nearly 96,000 full-time health-care professionals were needed to fill vacant nursing positions at nursing homes across the U.S.

With the baby boomers aging, it's going to be crucial to develop innovative ways to prevent disease in the elderly, Bender said. According to the U.S. Administration on Aging, by the year 2030, the older population will have more than doubled to 71.5 million. Within that cohort, 9.6 million people will be 85 years old or older.

While the proportion of Americans aged 65 and older who have a chronic disability has been declining (from 24 percent in 1982 to 21 percent in 1994), the number of disabled older Americans is increasing. In 1982, 6.4 million American seniors had a chronic disability; that number rose by 600,000, to 7 million in 1994.

"My uncle was in the hospital recently in Chicago for 12 days, and the bill was $100,000," Bender said. "If we can prevent just a handful of those hospitalizations from happening, think how much we can save. We think we can save the government so much money with the preventive care-model, that the system will more than pay for itself." *CK*

STATE HEALTH *NOTES*
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